

BOULDER
NEUROSURGICAL & SPINE
ASSOCIATES

Boulder · Longmont · Lafayette · Louisville · Brighton
· Denver Metro ·

CHART #: _____
FOR OFFICE USE ONLY

NEW PATIENT VISIT NECK

LAST NAME: _____ FIRST: _____ MI: _____

MAILING ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHYSICAL ADDRESS (IF DIFFERENT THAN MAILING): _____

CITY: _____ ST: _____ ZIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____ EXT: _____ MOBILE: (____) _____

PERMISSION TO USE MOBILE PHONE (INITIAL): _____ PREFERRED LANGUAGE: _____

BIRTH DATE: ____/____/____ AGE: ____ SEX: M F HGT: ____ WGT: ____ RACE: _____ ETHNICITY: _____
MO DAY YEAR

SOCIAL SECURITY NO.: _____ EMAIL ADDRESS: _____

MAY WE USE YOUR EMAIL FOR COMMUNICATION? NO YES

HAVE YOU BEEN SEEN BY A BOULDER NEUROSURGICAL PHYSICIAN BEFORE? NO YES

IF "YES" WHEN AND WHO: _____

WHO REFERRED YOU TO OUR OFFICE?: _____

PRIMARY CARE DOCTOR(S): _____

YOUR PHARMACY (INCLUDE CROSS STREETS): _____

CITY: _____ ST: _____ ZIP: _____

YOUR EMPLOYER: _____ OCCUPATION: _____

EMPLOYED RETIRED DISABLED DUE TO CURRENT CONDITION DISABLED DUE TO OTHER REASONS

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

EMERGENCY CONTACT (NOT LIVING WITH YOU)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

TELEPHONE#: (____) _____ MOBILE: (____) _____

I hereby acknowledge that I have been provided BNA's Notice of Privacy Practices and understand that I may, at any time, request to receive the full Notice of Privacy Practices from BNA, 4743 Arapahoe Ave, Suite 202, Boulder, CO 80303, 303-938-5700.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP: _____

Boulder Neurosurgical & Spine Associates

PLEASE LIST CURRENT MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID# _____ GROUP# _____

ADDRESS OF COMPANY: _____

CITY: _____ STATE: _____ ZIP: _____ TELEPHONE: (____) _____

POLICY HOLDER'S NAME: _____
LAST FIRST MI

TELEPHONE: (____) _____ MOBILE TELEPHONE: (____) _____

RELATIONSHIP: _____ DATE OF BIRTH: ____/____/____ SOCIAL SEC#: _____
MONTH DAY YEAR

EMPLOYER (FULL NAME): _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (____) _____ EXT.: _____

SECONDARY INSURANCE

POLICY HOLDER'S NAME: _____
LAST FIRST MI

RELATIONSHIP: _____ DATE OF BIRTH: ____/____/____ SOCIAL SEC#: _____
MONTH DAY YEAR

NAME OF INSURANCE COMPANY: _____ ID# _____ GROUP# _____

ADDRESS OF INSURANCE COMPANY: _____

CITY: _____ STATE: _____ ZIP: _____ TELEPHONE: (____) _____

PERSON RESPONSIBLE FOR ACCOUNT

MYSELF

OTHER LAST NAME: _____ FIRST NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ APT#: _____ CITY: _____ ST: _____ ZIP: _____

TELEPHONE: (____) _____ MOBILE: (____) _____

EMPLOYER (FULL NAME): _____ WORK PHONE#: (____) _____ EXT: _____

ADDRESS: _____ SUITE#: _____ CITY: _____ ST: _____ ZIP: _____

SOCIAL SECURITY #: _____ DRIVERS LICENSE#: _____ STATE: _____

AUTHORIZATION: I HEREBY AUTHORIZE BOULDER NEUROSURGICAL ASSOCIATES TO FURNISH INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY INJURY/ACCIDENT/CONDITION, AND I HEREBY IRREVOCABLY ASSIGN TO BOULDER NEUROSURGICAL ASSOCIATES ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____

Boulder Neurosurgical & Spine Associates

LAST NAME: _____ FIRST NAME: _____ MI: _____ AGE: _____

SOCIAL HISTORY

DO YOU LIVE ALONE? NO YES

DO YOU HAVE CHILDREN? NO I HAVE _____ CHILDREN

I HAVE SMOKED _____ PACK(S) PER DAY FOR _____ YEARS I NEVER SMOKED QUIT _____ YEARS AGO

I DO NOT DRINK ALCOHOL I DRINK ONLY SOCIALLY I DRINK DAILY. IF CHECKED, HOW MUCH? _____

ARE YOU AT RISK FOR HIV/AIDS? (BLOOD TRANSFUSIONS, DRUG USE, ETC.)? IF YES, PLEASE EXPLAIN _____

REVIEW OF THE SYSTEMS (PLEASE CHECK CONDITIONS THAT YOU CURRENTLY HAVE)

1. GENERAL

- RECENT FEVER/ CHILLS
- RECENT WEIGHT LOSS

2. EYES

- WEAR GLASSES

3. EAR, NOSE, THROAT AND MOUTH

- HEARING LOSS

4. RESPIRATORY

- ASTHMA
- EMPHYSEMA

5. CARDIOVASCULAR

- HEART DISEASE
- CHEST PAIN, ANGINA
- SHORTNESS OF BREATH
- HIGH BLOOD PRESSURE
- IRREGULAR PULSE
- HEART MURMUR

6. GASTROINTESTINAL

- BLOOD IN YOUR VOMIT

7. GENITOURINARY

- BLOOD IN URINE

9. NEUROLOGICAL

- HEADACHE
- DIZZINESS/ VERTIGO
- SEIZURES
- DIFFICULTY WITH SPEECH
- DOUBLE/ BLURRED VISION
- FACE WEAKNESS
- FACIAL PAIN

10. PSYCHOLOGICAL

- DEPRESSION

11. MUSCULOSCELETAL

- BACK PAIN
- LEG PAIN RT LT
- LEG WEAKNESS RT LT
- NECK PAIN
- ARM PAIN RT LT
- ARM WEAKNESS RT LT
- ARTHRITIS

12. BLOOD AND LYMPH

- BLEEDING TENDENCIES

PLEASE LIST ANY OTHER CONDITIONS/CONCERNS NOT MENTIONED ABOVE THAT YOU BELIEVE WOULD BE RELEVANT TO YOUR OFFICE VISIT _____

Boulder Neurosurgical & Spine Associates

LAST NAME: _____ FIRST NAME: _____ MI: _____ AGE: _____

DESCRIBE THE REASON FOR TODAY'S VISIT: _____

HAVE YOU HAD THE FOLLOWING TREATMENTS FOR YOUR CONDITION? (MARK ALL THAT APPLY)

- BRACING MASSAGE PHYSICAL THERAPY CHIROPRACTIC MANIPULATIONS
 SPINAL INJECTIONS TRACTION THERAPY SPINAL CORD STIMULATOR
 MORPHINE PUMP ALTERNATIVE MEDICINE THERAPIES NONE N/A

HAVE YOU HAD ANY PREVIOUS SURGERIES FOR THIS CONDITION? NO YES IF YES, WHICH LEVEL? _____

OTHER SURGERIES AND/OR HOSPITALIZATIONS	YEAR	SURGERY COMPLICATIONS
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE REQUEST AN ADDITIONAL SHEET IF NECESSARY

OTHER MEDICAL CONDITIONS (NOT INCLUDED ABOVE) _____

PLEASE REQUEST AN ADDITIONAL SHEET IF NECESSARY

MEDICATIONS THAT YOU ARE CURRENTLY TAKING:	DOSE	TIMES/ DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ANY BLOOD THINNERS (ASPIRIN, ADVIL, WARFARIN, ETC) AND HERBAL SUPPLEMENTS. PLEASE REQUEST AN ADDITIONAL SHEET IF NECESSARY

DO YOU HAVE ANY DRUG, IV DYE, LATEX OR FOOD ALLERGIES? NO YES IF YES, PLEASE LIST _____

ARE THERE ANY MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY? NO YES IF YES, PLEASE DESCRIBE: _____

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Boulder Neurosurgical & Spine Associates

PATIENT STATEMENT OF INJURY/ACCIDENT/CONDITION DETAILS

ARE YOU HERE AS A RESULT OF AN INJURY OR ACCIDENT? NO YES IF YES, PLEASE COMPLETE BELOW:

THIS INFORMATION IS FOR YOUR INSURANCE COMPANY. CLAIMS MAY NOT BE PAID IF INFORMATION IS NOT ACCURATE.

PATIENT NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____ / _____ / _____
MONTH DAY YEAR

FULL TIME STUDENT NO YES IF YES, NAME OF SCHOOL: _____

PRIMARY INSURANCE COMPANY: _____ ID#: _____

OTHER INSURANCE? NO YES

IF YES, PLEASE EXPLAIN: _____

DETAILS OF THE ACCIDENT:

AUTO ACCIDENT WORK INJURY RECREATIONAL ACCIDENT HOME ACCIDENT OTHER ACCIDENT

DATE OF INJURY: _____ / _____ / _____
MONTH DAY YEAR

WHERE DID THIS OCCUR? _____

AUTHORIZATION: I HEREBY AUTHORIZE **BOULDER NEUROSURGICAL ASSOCIATES** TO FURNISH THIS INFORMATION TO MY INSURANCE CARRIERS CONCERNING MY INJURY/ACCIDENT/CONDITION.

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

PRINT NAME: _____

THIS FORM IS TO BE SENT WITH THE FIRST VISIT INSURANCE CLAIM FORM.

Boulder Neurosurgical & Spine Associates

MEDICAL INFORMATION DISTRIBUTION/RELEASE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

II. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name _____ Phone _____

Name _____ Phone _____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES _____ NO _____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

() _____

* I am fully aware that a cell phone is not a secure and private line.

** I am fully aware my health information can be transmitted by facsimile (fax), mail or the internet.

VI. Can confidential messages (i.e., appointment reminders) be left on your home answering machine, voicemail or sent via email?

YES _____ NO _____

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Boulder Neurosurgical & Spine Associates

LAST NAME: _____ FIRST NAME: _____ MI: _____ AGE: _____

PLEASE CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN ON AVERAGE IN THE LAST 7 DAYS

NECK PAIN NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN

ARM PAIN NO PAIN 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN

ARE YOU EXPERIENCING THE FOLLOWING SYMPTOMS:

WEAKNESS IN YOUR ARMS LEFT RIGHT

DIFFICULTIES WITH BOWEL AND/ OR BLADDER

IF YOU ARE EXPERIENCING NECK OR ARM PAIN, PLEASE ANSWER THE FOLLOWING:

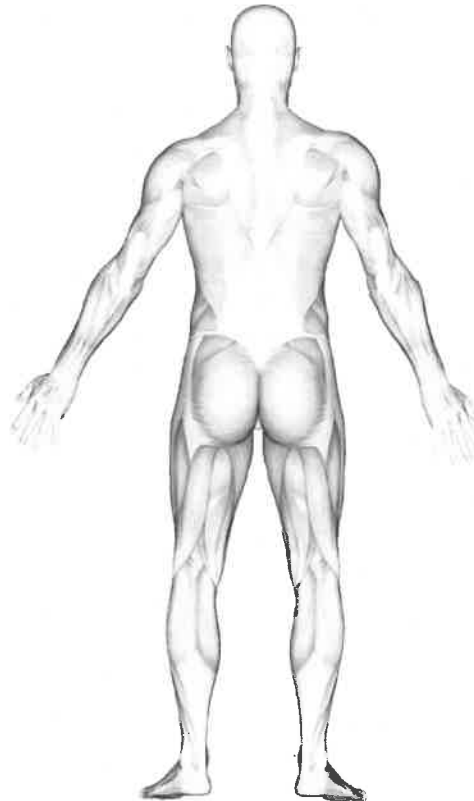
PLEASE MARK THESE DRAWINGS ACCORDING TO WHERE YOU HURT USING THE KEY BELOW TO ILLUSTRATE THE CHARACTER OF YOUR PAIN. MARK A CIRCLED "X" IN THE ONE PLACE YOUR PAIN IS MOST SEVERE.

SHOOTING-STABBING
////////

BURNING / ACHING
~~~~~

**PINS & NEEDLES**  
+++++++

**NUMBNESS**  
000000



SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

# Neck Disability Index (NDI) Questionnaire

|                                           |                                           |                                            |                                            |
|-------------------------------------------|-------------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Preoperative     | <input type="checkbox"/> 6 Week Follow-Up | <input type="checkbox"/> 3 Month Follow-Up | <input type="checkbox"/> 6 Month Follow-Up |
| <input type="checkbox"/> 1 Year Follow-Up | <input type="checkbox"/> 2 Year Follow-Up | <input type="checkbox"/> Unscheduled       |                                            |

**INSTRUCTIONS:** Could you please complete this questionnaire. It is designed to give us information as to how your neck (or arm) trouble has affected your ability to manage in everyday life. Please answer **every section**. Mark **one box only** in each section that most closely describes you today.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>1. Pain Intensity</b></p> <p>0 <input type="checkbox"/> I have no pain at the moment.</p> <p>1 <input type="checkbox"/> The pain is very mild at the moment.</p> <p>2 <input type="checkbox"/> The pain is moderate at the moment.</p> <p>3 <input type="checkbox"/> The pain is fairly severe at the moment.</p> <p>4 <input type="checkbox"/> The pain is very severe at the moment.</p> <p>5 <input type="checkbox"/> The pain is the worst imaginable at the moment.</p>                                                                                                                                                                                            | <p><b>2. Personal Care (Washing, Dressing, Etc.)</b></p> <p>0 <input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p>1 <input type="checkbox"/> I can look after myself normally, but it is very painful.</p> <p>2 <input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p>3 <input type="checkbox"/> I need some help, but manage most of my personal care.</p> <p>4 <input type="checkbox"/> I need help everyday in most aspects of self-care.</p> <p>5 <input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.</p>                                                     |
| <p><b>3. Lifting</b></p> <p>0 <input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p>1 <input type="checkbox"/> I can lift heavy weights, but it gives extra pain.</p> <p>2 <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on a table.</p> <p>3 <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p>4 <input type="checkbox"/> I can lift only very light weights.</p> <p>5 <input type="checkbox"/> I cannot lift or carry anything at all.</p> | <p><b>4. Reading</b></p> <p>0 <input type="checkbox"/> I can read as much as I want with no neck pain.</p> <p>1 <input type="checkbox"/> I can read as much as I want with slight neck pain.</p> <p>2 <input type="checkbox"/> I can read as much as I want with moderate neck pain.</p> <p>3 <input type="checkbox"/> I cannot read as much as I want because of moderate neck pain.</p> <p>4 <input type="checkbox"/> I can hardly read at all because of severe neck pain.</p> <p>5 <input type="checkbox"/> I cannot read at all.</p>                                                                                                                                             |
| <p><b>5. Headaches</b></p> <p>0 <input type="checkbox"/> I have no headaches at all.</p> <p>1 <input type="checkbox"/> I have slight headaches which come infrequently.</p> <p>2 <input type="checkbox"/> I have moderate headaches which come infrequently.</p> <p>3 <input type="checkbox"/> I have moderate headaches which come frequently.</p> <p>4 <input type="checkbox"/> I have severe headaches which come frequently.</p> <p>5 <input type="checkbox"/> I have headaches almost all the time.</p>                                                                                                                                                                  | <p><b>6. Concentration</b></p> <p>0 <input type="checkbox"/> I can concentrate fully when I want with no difficulty.</p> <p>1 <input type="checkbox"/> I can concentrate fully when I want with slight difficulty.</p> <p>2 <input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want.</p> <p>3 <input type="checkbox"/> I have a lot of difficulty in concentrating when I want.</p> <p>4 <input type="checkbox"/> I have a great deal of difficulty in concentrating when I want.</p> <p>5 <input type="checkbox"/> I cannot concentrate at all.</p>                                                                                                 |
| <p><b>7. Work</b></p> <p>0 <input type="checkbox"/> I can do as much work as I want.</p> <p>1 <input type="checkbox"/> I can only do my usual work, but no more.</p> <p>2 <input type="checkbox"/> I can do most of my usual work, but no more.</p> <p>3 <input type="checkbox"/> I cannot do my usual work.</p> <p>4 <input type="checkbox"/> I can hardly do any work at all.</p> <p>5 <input type="checkbox"/> I cannot do any work at all.</p>                                                                                                                                                                                                                            | <p><b>8. Driving</b></p> <p>0 <input type="checkbox"/> I can drive my car without any neck pain.</p> <p>1 <input type="checkbox"/> I can drive my car as long as I want with slight neck pain.</p> <p>2 <input type="checkbox"/> I can drive my car as long as I want with moderate neck pain.</p> <p>3 <input type="checkbox"/> I cannot drive my car as long as I want because of neck pain.</p> <p>4 <input type="checkbox"/> I can hardly drive at all because of severe neck pain.</p> <p>5 <input type="checkbox"/> I cannot drive my car at all.</p>                                                                                                                           |
| <p><b>9. Sleeping</b></p> <p>0 <input type="checkbox"/> My sleep is never disturbed by pain.</p> <p>1 <input type="checkbox"/> My sleep is occasionally disturbed by pain.</p> <p>2 <input type="checkbox"/> Because of pain I have less than 6 hours sleep.</p> <p>3 <input type="checkbox"/> Because of pain I have less than 4 hours sleep.</p> <p>4 <input type="checkbox"/> Because of pain I have less than 2 hours sleep.</p> <p>5 <input type="checkbox"/> Pain prevents me from sleeping at all.</p>                                                                                                                                                                 | <p><b>10. Recreation</b></p> <p>0 <input type="checkbox"/> I can engage in all my recreating activities with no neck pain at all.</p> <p>1 <input type="checkbox"/> I can engage in all my recreating activities with some neck pain.</p> <p>2 <input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of neck pain.</p> <p>3 <input type="checkbox"/> I am able to engage in a few of my usual recreation activities because of neck pain.</p> <p>4 <input type="checkbox"/> I can hardly do any recreation activities because of neck pain.</p> <p>5 <input type="checkbox"/> I cannot do any recreation activities at all.</p> |

Please do not erase or cover mistake with correction fluid or tape. Line through the mistake once, initial and date next the correction.

Subject Initials: \_\_\_\_\_ Date: \_\_\_\_\_



# SF-12 Health Survey Questionnaire

|                                           |                                           |                                            |                                            |
|-------------------------------------------|-------------------------------------------|--------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Preoperative     | <input type="checkbox"/> 6 Week Follow-Up | <input type="checkbox"/> 3 Month Follow-Up | <input type="checkbox"/> 6 Month Follow-Up |
| <input type="checkbox"/> 1 Year Follow-Up | <input type="checkbox"/> 2 Year Follow-Up | <input type="checkbox"/> Unscheduled       |                                            |

**INSTRUCTIONS:** This questionnaire asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer every question by marking one box. If you are unsure about how to answer, please give the best answer you can.

1. In general, would you say your health is:

|                                    |                                    |                               |                               |                               |
|------------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Very Good | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
|------------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

|                                                                                                           | Yes, Limited A Lot       | Yes, Limited A Little    | No, Not Limited At All   |
|-----------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 2. <b>Moderate activities</b> , such as moving a table, pushing a vacuum cleaner, bowling or playing golf | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Climbing <b>several</b> flights of stairs                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

|                                                                | Yes                      | No                       |
|----------------------------------------------------------------|--------------------------|--------------------------|
| 4. <b>Accomplished less</b> than you would like                | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Were <b>limited</b> in the kind of work or other activities | <input type="checkbox"/> | <input type="checkbox"/> |

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

|                                                                | Yes                      | No                       |
|----------------------------------------------------------------|--------------------------|--------------------------|
| 6. <b>Accomplished less</b> than you would like                | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Were <b>limited</b> in the kind of work or other activities | <input type="checkbox"/> | <input type="checkbox"/> |

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

|                                     |                                       |                                     |                                      |                                    |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Not at all | <input type="checkbox"/> A little bit | <input type="checkbox"/> Moderately | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Extremely |
|-------------------------------------|---------------------------------------|-------------------------------------|--------------------------------------|------------------------------------|

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks –

|                                         | All of the Time          | Most of the Time         | A Good Bit of the Time   | Some of the Time         | A Little of the Time     | None of the Time         |
|-----------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 9. Have you felt calm and peaceful?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Did you have a lot of energy?       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you felt downhearted and blue? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

|                                          |                                           |                                                 |                                           |                                               |                                           |
|------------------------------------------|-------------------------------------------|-------------------------------------------------|-------------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> All of the time | <input type="checkbox"/> Most of the time | <input type="checkbox"/> A Good bit of the time | <input type="checkbox"/> Some of the time | <input type="checkbox"/> A little of the time | <input type="checkbox"/> None of the time |
|------------------------------------------|-------------------------------------------|-------------------------------------------------|-------------------------------------------|-----------------------------------------------|-------------------------------------------|

Subject Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Boulder Neurosurgical & Spine Associates**

**Patient Financial Policy**

1. I understand it is my responsibility to provide all referral forms, referral numbers and insurance cards needed to process my claim at the time of service.
2. All visits not covered by your insurance policy are to be paid at the time of service. It is the patient's responsibility to understand his/her insurance benefits.
3. All accounts, which are 90 days past the date of service, may be sent to collections, unless prior arrangements have been made.
4. I understand it is my responsibility to notify this office of any insurance changes.

Patient No Show Policy: A \$50 charge will be assessed if a patient fails to show up to their appointment without 24 hour notification.

Patient Payment Policy: Patients who are covered under an insurance plan are responsible for all co-pays, deductibles, and co-insurance amounts. Co-pays will be collected at the time of service. Once insurance has been filed and an explanation of benefits received, any amount indicated as patient responsibility will be billed to the patient or responsible party.

Returned Check Policy: All returned checks will be issued a \$25.00 fee to be billed to the patient. If a patient writes one insufficient fund check, the patient may clear their account by paying the \$25.00 service fee, in addition to the account balance, and may keep their check writing privileges. If the patient writes a second insufficient fund check, the account must be cleared and the service fee of \$25.00 paid, but check writing privileges will be revoked. The account would then be deemed "CASH ONLY".

Collection Agency Policy: Once insurance is billed and services have been processed, any patient balance is expected from the patient within the 30 days, unless other arrangements have been made. If the patient does not make payment on their account within 30 days, the account may be turned over to an outside collections agency. At which time additional fees may be incurred.

I have read and understand the above information.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

# HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Boulder Neurosurgical & Spine Associates may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## I. My Authorization

I authorize \_\_\_\_\_ to use or disclose the following health information:

- All of my health information
- My health information relating to the following treatment or condition:  
\_\_\_\_\_
- My health information covering the period of healthcare from \_\_\_\_\_ (Start Date) to \_\_\_\_\_ (End Date).
- Other: \_\_\_\_\_

**The above party may disclose this health information to the following recipient:**

Name/Organization: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**The purpose of this authorization is (check all that apply):**

- At my request
- To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.
- To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.
- Other: \_\_\_\_\_

**This authorization ends:**

- On (Date): \_\_\_\_\_  When I am no longer a patient of the practice.
- When the following event occurs: \_\_\_\_\_

## II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is a minor or unable to sign please complete the following:

- Patient is a minor: \_\_\_\_\_ years of age
- Patient is unable to sign because: \_\_\_\_\_

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Representative: \_\_\_\_\_

Authority of representative to sign on behalf of patient:

- Parent  Legal Guardian  Court Order  Other: \_\_\_\_\_

## III. Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

- I consent  I do not consent

Signature of Patient or Authorized Representative: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

## IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

- I consent  I do not consent

Signature of Patient or Authorized Representative: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

## V. Notice of Privacy Practices

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.

Signature of Patient or Authorized Representative: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Your Information. Your Rights. Our Responsibilities.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

**Your Rights**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

**ASK US TO CORRECT YOUR MEDICAL RECORD**

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

**REQUEST CONFIDENTIAL COMMUNICATIONS**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

**ASK US TO LIMIT WHAT WE USE OR SHARE**

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

**GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION**

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a

reasonable, cost-based fee if you ask for another one within 12 months.

**GET A COPY OF THIS PRIVACY NOTICE**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**CHOOSE SOMEONE TO ACT FOR YOU**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

**FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED**

- You can complain if you feel we have violated your rights by contacting us at 303-938-5700.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints)
- We will not retaliate against you for filing a complaint.

**Your Choices**

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

#### **Our Uses and Disclosures**

#### **HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?**

We typically use or share your health information in the following ways:

#### **TREAT YOU**

We can use your health information and share it with other professionals who are treating you.

*Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

#### **RUN OUR ORGANIZATION**

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

*Example: We use health information about you to manage your treatment and services.*

#### **BILL FOR YOUR SERVICES**

We can use and share your health information to bill and get payment from health plans or other entities.

*Example: We give information about you to your health insurance plan so it will pay for your services.*

#### **HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

#### **HELP WITH PUBLIC HEALTH AND SAFETY ISSUES**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

#### **DO RESEARCH**

We can use or share your information for health research.

#### **COMPLY WITH THE LAW**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### **RESPOND TO ORGAN AND TISSUE DONATION REQUESTS**

We can share health information about you with organ procurement organizations.

#### **WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

#### **ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

#### **RESPOND TO LAWSUITS AND LEGAL ACTIONS**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

#### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

#### **FOR MORE INFORMATION SEE:**

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

#### **CHANGES TO THE TERMS OF THIS NOTICE**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.